



Title: Software Helps Providers Hit the Correct Billing Codes

Pub: ***Health Data Management***

Detail: John McCormack. (August 1998): p61. (2166 words)

Full Text: COPYRIGHT 1998 Thomson Financial Inc.

John McCormack

The Health Care Financing Administration has amassed regulations for Medicare and Medicaid claims that are even more complex than the notoriously complicated regulations promulgated by the Internal Revenue Service. That's what Jane M. Orient, M.D., executive director of the Association of American Physicians and Surgeons Inc., recently testified before a U.S. House of Representatives committee.

Faced with the prospect of being slapped with fines for filing fraudulent Medicare and Medicaid claims if they don't follow regulations to the letter, some health care providers are relying on coding software to help them comply with federal regulations as well as the requirements of other payers.

The complexity of coding regulations points to the need for automation. Medicare regulations run to 42,000 pages, and coding updates are issued monthly by the American Medical Association.

What's more, the government's zeal to crack down on coding compliance is pushing health care providers to take the issue seriously. Since 1994, when the government estimated that fraud, waste and abuse in Medicare and Medicaid amounted to between \$80 billion and \$100 billion annually, the push to get health care providers to comply with regulations has been moving ahead at full speed. The Clinton administration has authorized the deployment of thousands of fraud and abuse investigators from such government agencies as the Office of the Inspector General, the Justice Department and the Federal Bureau of Investigation.

A \$1 billion probe

Three out of four hospitals will be targeted in the government's \$1 billion probe into Medicare fraud and abuse. Health care compliance is the government investigators' No. 2 priority, just behind wiping out violent crime.

Many health care organizations already have been stung. Within the past three years, the Clinical Practices of the University of Pennsylvania, Thomas Jefferson Faculty Foundation, Smith-Kline Labs, National Medical Enterprises and Damon Clinical Labs each have paid the federal government from \$12 million to \$500 million in false claims settlements. Each settlement involved some issue of improper coding. And Columbia/HCA Healthcare Corp., the nation's largest for-profit health care provider, grabbed headlines last year when the federal government's over-billing allegations resulted in the ouster of top executives.

Despite these efforts, the government contends that many health care providers still are submitting erroneous claims. The second annual financial audit of HCFA's financial performance, released in April, found that 11% of Medicare claims - or about \$20 billion worth - were improperly paid in 1997 (see chart, page 69).

A computerized assist

The government's continued emphasis on regulatory compliance should help fuel demand for software applications that help assure proper coding of claims.

'The government's increased attention to coding compliance has created more awareness of the accuracy issue,' says Tom Kuras, a partner with the consulting firm Coopers & Lybrand's health care regulatory group in Albany, New York. 'The concern for coding accuracy has bubbled up higher in organizations than it has in the past. That means that the demand for software coding tools will continue to increase. These automated compliance tools are here to stay.'

Many providers already are using software to make sure, for example, that codes for procedures and treatments are supported by correct diagnoses.

To be reimbursed by Medicare for procedures and treatments, health care providers must submit two codes - an International Classification of Diseases, 9th Revision code, and a Current Procedural Terminology code. The ICD-9 code is used to place a patient into a diagnosis related group. The CPT code identifies specific procedures or treatments. To comply with Medicare rules, providers are required to submit an ICD-9 code that supports the CPT code. In other words, Medicare only allows certain procedures and tests to be ordered with certain diagnoses.

Making sure that procedures and tests (CPT codes) are supported by the right diagnoses (ICD-9 codes) can be a cumbersome process, considering that there are thousands upon thousands of possible permutations. Providers are required to notify patients if no ICD-9 code supports a certain test or procedure. Medicare does not reimburse for such tests and procedures.

In such cases, the health care provider is required to give the patient an 'advanced beneficiary notice,' a form that spells out that the patient will be personally responsible for payment. If the hospital fails to notify the patient, it can be convicted of fraudulent billing. What's more, if the health care provider fails to add a two-digit code to the CPT code signifying they are aware that the test or procedure won't be covered by Medicare, this also can result in a finding of fraud.

Manual mayhem

Manually looking through manuals to match up ICD-9 and CPT codes is a daunting task, says Mike Badella, clinical director of diagnostic services at Madera (Calif.) Community Hospital. 'It is just so difficult. We have manuals full of ICD-9 codes. To expect office workers to manually do it is unreasonable. They just aren't able to do it,' he says.

Because it is so difficult to cross-check the thousands of codes manually, Madera has automated the process. The hospital uses a combination of software. Codebreaker Software from Info-X Inc., Tenaflly, N.J., uses an integrated data file to cross-reference ICD-9 and CPT codes. This function is then integrated into ordering software from Valcomm Inc., Reseda, Calif.

When a clinician orders a test in the Valcomm software, the Codebreaker software is immediately prompted to check to see that the test is supported by an ICD-9 code. If it is not supported, it will automatically flag the test and print an advanced notice directive.

'The cross-walk feature reduces claims denials and the risk for a fraud and abuse investigation,' says Avi Sacajui, president of Info-X.

Deaconess Billings Clinic, an integrated delivery network with a 160- bed hospital and seven clinics, also turned to automation to help stay in compliance with Medicare regulations. The Billings, Mont.-based provider uses HELP order communications software from 3M Health Information Systems, Salt Lake City. The software checks to make sure that ICD-9 codes support all treatment orders. If the orders are not supported, 'The system will tell us that the diagnostic code is not approved, and the patient needs to sign a waiver,' says Dennis Regan, M.D., medical director of information systems at the hospital.

The software has helped the hospital solve a 'huge problem with compliance,' Regan says. Since implementing the software in February, Deaconess Billings has gone from submitting about 40% of its Medicare claims with coding errors to submitting claims with virtually no errors, Regan says.

Regan also has devised ways to use Master Member Index software from 3M to help the hospital comply with Medicare regulations. Although the software was not purchased for this purpose, Regan says that it is a natural application. 'The reason we bought the MMI software was because we wanted to put all the clinical information together for each patient. We wanted to provide one-stop shopping for the clinician. But we have been able to add functions that put us in better regulatory compliance, even though that was not the initial force behind the decision to purchase the software,' Regan says.

The 72-hour rule

For example, the hospital will use MMI software from 3M to help it comply with Medicare's Diagnosis-Related Group 72-hour window rule. This regulation stipulates that hospitals cannot bill Medicare for outpatient services delivered within 72 hours of a related inpatient admission. These services must be billed under one lump-sum DRG payment. Since implementing the rule in 1988, the Department of Health and Human Services has netted almost \$100 million in settlements.

Regan has added rules-based logic to the MMI software to help Billings steer clear of the 72-hour problem. Patients' registration data is immediately entered into the MMI software during admission and the logic then lumps all tests ordered within 72 hours after hospital admission under the DRG payment. Tests ordered after 72 hours then are billed independently.

The MMI software also will be used to help the hospital cut down on the number of duplicate charges submitted to Medicare. For example, when two physicians bill Medicare for one diagnosis, only one doctor will get paid.

'I'm a general internist. Say I admit a patient and then consult with gastroenterology. Only one of us gets paid for the treatment if we are working off of the same diagnosis,' Regan says. 'Because everything is online, it is easier to review what others are billing for. Before, everybody kept his own codes on a little piece of paper and you wouldn't know what people are billing for.'

In addition to helping them comply with regulations, a number of health care providers are finding that software can help them get full reimbursement for the services rendered.

'Since I have been in the coding software business, I have seen a transition away from doctors wanting to maximize revenue to doctors really being concerned about compliance,' says Gary Knause, director of

operations at ADP Context, a Burr Ridge, Ill.-based coding software vendor. 'But providers can optimize legitimate reimbursement or revenue. Using the term 'revenue maximization' has bad connotations. Some doctors did game the system by billing aggressively. But there is still a lot of money being left on the table for legitimate services that are not being billed correctly.'

Fewer denials

Loma Linda (Calif.) University Medical Center, for example, has reduced Medicare payment denials by 80% with the use of the Claims Editor from Context. The software helps the billing office identify when certain procedures should be billed separately and not as part of a lump-sum payment.

'Medicare rules dictate that followup visits within 90 days after surgery should be paid under one charge. But sometimes the procedure could be for a new problem or a complication. These can be billed separately if a modifier is added to the code,' says Tony Pena, billing manager.

Another barrier to full reimbursement is the fact that coders are not always aware of when they can bill two CPT codes simultaneously. Candy Jonas, coding specialist at Crystal Clinic, Akron, Ohio, uses Codelink software from ADP Context to verify when two codes can be submitted on the same bill. 'You can punch in a code and it will tell you if you can or cannot bill another code with it,' Jonas says.

The software also enables Jonas to verify whether the services of physicians or surgical assistants can be billed with certain codes.

Although coding software gives health care providers a financial boost by helping to get full reimbursement, it also can help the bottom line through increased productivity, says Tom Anthony, assistant administrator and CIO at Springfield (Ill.) Clinic.

'We used to routinely be 10 to 11 days backed up in coding claims for submission. Now we are never more than three or four days behind,' he says. Because the group practice can code claims more efficiently, it gets reimbursed quicker, improving overall cash flow.

Using Context software also has helped the clinic increase coding volume without increasing its coding staff.

'If we weren't automated we would have added two coders, but we have been able to handle the extra volume with our existing staff,' Anthony says.

Software also can increase productivity by helping compliance officers keep track of changing regulations.

Joanne Rosenthal, R.N., corporate compliance officer at Thomas Jefferson University, Philadelphia, uses ComplySource from Cabot Marsh, a division of QuadraMed Corp., Bethlehem, Pa., to stay on top of the regulations and notices published by HCFA, Office of the Inspector General and other agencies. The software provides quarterly updates on regulatory activities to help coding personnel stay abreast of crucial developments. For example, a recent update pointed out that the OIG is targeting pneumonia codes for overutilization.

'When you talk about coding compliance, you are talking about staying on top of a broad spectrum of information. I get printed notices and policies, but it is nice to have it all in one location electronically,' Rosenthal says.

By using such software, provider organizations are demonstrating they are making an effort to comply with coding regulations, says Rosenthal, who also is an attorney. 'Purchasing software is probably some evidence of a good-faith effort that you are trying to comply with regulations,' she adds.

Buyer beware

Although coding software can help health care providers comply with regulations, receive warranted reimbursement and stay on top of changing rules, some experts are warning health care organizations that using software will not automatically bring them into regulatory compliance.

Providers should not rely 100% on computerized encoders. Instead, providers should employ knowledgeable coding staff who use coding manuals in addition to software support, Coopers & Lybrand's Kuras says.

Providers also should investigate how the software they're considering buying was developed, Kuras warns. 'In some cases, you have vendors who were out there selling their wares as revenue-maximization software. Now the rules have changed and they are marketing their software as something that will help facilities comply with regulations. I question those vendors,' Kuras says. 'If the software is just a recast maximization tool, it might not have all the compliance elements in it.'

Source Citation

McCormack, John. "Software Helps Providers Hit the Correct Billing Codes." *Health Data Management* (1998): 61. *General OneFile*. Web. 19 Jan. 2010. <<http://find.galegroup.com/gtx/start.do?prodId=ITOF&userGroupName=birm97026>>.

Gale Document Number:A50272841

- [Contact Us](#)
- [Copyright](#)
- [Terms of use](#)
- [Privacy policy](#)